KANSAS STATE EMPLOYEES HEALTH PLAN

Use of Authorizations Policy Statement

This policy and procedure is adopted pursuant to Section 164.508 of the privacy rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If the privacy rules are changed by HHS, the Plan will follow the revised rules.

USE OF AUTHORIZATIONS PRIVACY EFFECTIVE DATE

April 14, 2003

USE OF AUTHORIZATIONS PRIVACY POLICY

Except as otherwise provided under the privacy regulations or other applicable law, the Plan may not use or disclose PHI without a valid authorization. An authorization is not required for use or disclosure of PHI for treatment, payment or health care operations or for uses or disclosures otherwise permitted under the privacy rules.

If an authorization is asked for or received, the Plan will only use or disclose PHI in a manner consistent with the authorization.

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Use of Authorizations Procedures

1. A valid authorization is required for any use or disclosure of PHI, except as provided under these procedures or under the privacy regulations.

2. An authorization is not required for use or disclosure of PHI for treatment, payment or health care operations.

3. If the Plan seeks an authorization for a use or disclosure of PHI, the Plan must provide the individual with a copy of the signed authorization.

4. The Privacy Official will make a determination as to whether a specific use or disclosure of PHI requires an authorization.

5. The Plan will obtain an authorization for the use or disclosure of psychotherapy notes except:

    a. Use or disclosure by the Plan to defend a legal action, or

    b. Use or disclosure to the Secretary of Health and Human Services (HHS) regarding compliance with HIPAA privacy rules,

    c. Use or disclosure as required by law,

    d. Use or disclosure for health oversight activities with respect to the oversight of the originator of the notes,

    e. Use or disclosure to coroners and medical examiners,

    f. Use or disclosures to an individual, when requested under, and as required by their right to inspect, copy and receive an accounting of their PHI,

    g. Use or disclosures, consistent with applicable law and standards of ethical conduct, where the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

5. The Plan will use authorizations for marketing purposes. Refer to the Plan's Marketing Policy for more information.

6. If the Privacy Official, or his or her designee, determines that an authorization is required, then the Plan will attempt to obtain a valid authorization from the individual.

7. The Privacy Official, or his or her designee, will use the Plan's authorization form. Additional information may be included on the form as long as it is not inconsistent with the form.

8. When the form is completed and sent back by the covered individual, the Privacy Official, or his or her designee, will review the form to ensure that it is signed and complete. If the form has not been signed, is not properly completed or is otherwise defective, the Privacy Official, or his or her designee, will re-send the form to the covered individual within ten business days. The authorization must have an expiration date or event and must be signed and dated.

9. An authorization is not valid if:

    a. The expiration date has passed or the expiration event is known by the Privacy Official to have occurred.

    b. The authorization has not been filled out completely.

    c. The authorization is known by the Privacy Official to have been revoked.

    d. Any material information in the authorization is known by the Privacy Official to be false.

11. Authorizations should be on separate forms. If two authorizations are required, separate forms should be used.

12. The Plan will generally not condition the provision to an individual of treatment, payment, enrollment or eligibility on receipt of an authorization from the individual. However, the Plan may condition enrollment in the plan or eligibility for benefits on receipt of authorization prior to enrollment, if the authorization is sought for underwriting or risk rating determinations and does not relate to psychotherapy notes.

13. If a personal representative signs the authorization form, then there must be proof of the representative's authority on file with the Privacy Official.

14. An individual may revoke an authorization at any time by providing a signed written notice to the Privacy Official by mail, or hand-delivery. An oral revocation will not be valid. A revocation will not be valid to the extent the Plan has relied on the authorization.

15. The Privacy Official will retain all authorizations for at least six years from the expiration date of the authorization.

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Authorization Form

Authorization For Release of Medical Information

I [*name of individual*] hereby authorize the use or disclosure of my health information as described in this authorization.

1. Specific person/organization (*or class of persons*) authorized to provide the information:

_____

_____

2. Specific person/organization (*or class of persons*) authorized to receive and use the information:

_____

_____

3. Specific and meaningful description of the information:

   Please describe the information you wish the Plan to disclose, for example:

   ☐ *Written and electronic information related to eligibility for benefits for the time period commencing on _____ date and continuing through _____ date.*

   ☐ *Written and electronic information including claims, reports, and other documents related to claims for benefits for an injury or illness commencing on ____ date and continuing through _____ date.*

   ☐ *Written and electronic information relating to payment or lack of payment of benefits to [name of health care provider] for services rendered on _____ [date.*]

   ☐ Other:

   _____

   _____

4. Purpose of the request:

   Please state the purpose of the request below. [for example*, to discuss my benefits with the Fund and its TPA so that I can better understand my benefits.*] If you do not wish to state a purpose, please state, "At the request of the individual."

   _____

   _____

5. Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying the person/organization listed in number 1 above in writing at [*list address to which revocation must be delivered*]. I understand that the revocation is only effective after it is received and logged by the person/organization listed in number 1 above. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

6. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.

7. I understand that I am entitled to receive a copy of this authorization.

8. I understand that this authorization will expire on [*insert an expiration date or event, for example, one year*].

   _____

   _____

9. The Plan will not condition treatment, payment, enrollment or eligibility for health plan benefits on receipt of an authorization.

_____ _____

Signature of Individual Date

If a Personal Representative executes this form, that Representative warrants that he/she has authority to sign the form on the basis of:

_____

_____

_____

This authorization reflects the requirements of 45 CFR § 164.508 (August 14, 2002).